Financial Analysis

Iowa's financial model projects eligibility and expenditures with and without the Medicaid ACO program. The results of this analysis rely upon information provided by the State, internal data, publicly available information on other programs, fee-for-service (FFS) claims, eligibility data, and ACO Tax ID's for providers participating or expected to participate in the Iowa ACO Program by 2016.

The data and program descriptions provided by Iowa DHS was used to determine the Medicaid recipients meeting the eligibility requirements of the ACO Payment Structure and served by ACO providers. The following groups (and their associated claims) were excluded:

- Members on the Brain Injury, Intellectual Disability, and Health and Disability Waivers
- Medically Needy
- Presumptive Eligibility
- Undocumented Aliens
- IFPN

Eligible members and their associated claims were classified into the providers using the list of ACO Tax ID's participating in the ACO program. In addition to currently defined eligibles, a 20% per year growth was assumed in those enrolled in the ACO program as the program is expanded and an increase in the disabled groups of 10% is assumed in 2018 as Nursing Home is added. Iowa Medicaid fiscal agent month-end claims files were provided by the state for claims paid from June 1, 2013 through May 31, 2014. Claims were matched to the eligibility file to include claims for Medicaid recipients currently eligible for the ACO Payment Structure program.

Table 1
Total Eligible Population Member Months

	CY 2016	CY 2017	CY 2018
Medicaid Adult	78,595	94,314	113,177
Wellness Plan	469,128	562,954	675,544
Medicaid Child	215,864	259,037	310,844
Dual Eligibles	70,881	85,057	112,276
Disabled/Elderly (non Dual)	63,314	75,977	100,289
Medicare	1,007	1,208	1,595

Total Cost of Care (TCOC)

The estimated TCOC includes the following:

(a) Fee-for-service (FFS) payments trended at 4.7% per year
(b) Healthcare Management
(c) Shared Savings

The state currently pays for services through FFS, Primary Care Case Management (PCCM), and managed care programs.

The state has decided to phase-in the services to be included in the Total Cost of Care.

Year 1 – All services for covered population except Magellan Behavioral Health (BH), Nursing Home Services, and ICF/ID Services.

Year 2 – All services for covered population except Nursing Home.

Year 3 – All services are included

Table 2 shows the projected medical cost without the ACO program

Table 2 Medical Cost PMPM Without ACO Program			
	CY 2016	**CY 2017**	**CY 2018**
Medicaid Adult	$450.09	$471.24	$493.39
Wellness Plan	$409.55	$428.79	$448.95
Medicaid Child	$218.83	$229.11	$239.88
Dual Eligibles	$376.65	$394.35	$412.89
Disabled/Elderly	$1,385.93	$1,451.06	$1,519.26
Medicare	$15.02	$15.73	$16.47

Table 3 shows the projected medical cost before shared savings.

Table 3 Total Cost of Care PMPM with ACO Program Before Shared Savings			
	CY 2016	**CY 2017**	**CY 2018**
Medicaid Adult	$408.36	$427.56	$447.65
Wellness Plan	$371.58	$389.05	$407.33
Medicaid Child	$198.99	$208.34	$218.13
Dual Eligibles	$343.22	$359.36	$376.25
Disabled/Elderly	$1,271.88	$1,331.66	$1,394.24
Medicare	$13.42	$14.05	$14.71

Table 4 shows the shared savings according to the percentages in table 11 below and is equal to (Table 2 minus Table 3) x Table 11

Table 4 Shared Savings (See Table 11 Below)			
	CY 2016	**CY 2017**	**CY 2018**
Medicaid Adult	$10.43	$13.10	$16.01
Wellness Plan	$9.49	$11.92	$14.57
Medicaid Child	$4.96	$6.23	$7.61
Dual Eligibles	$8.36	$10.50	$12.82
Disabled/Elderly	$28.51	$35.82	$43.76
Medicare	$0.40	$0.50	$ 0.62

Table 5 shows the total cost of care after savings are shared and is equal to Table 3 plus Table 4.

Table 5 Total Cost of Care PMPM with ACO Program After Sharing Savings			
	CY 2016	**CY 2017**	**CY 2018**
Medicaid Adult	$418.79	$440.66	$463.66
Wellness Plan	$381.07	$400.97	$421.90
Medicaid Child	$203.95	$214.57	$225.74
Dual Eligibles	$351.58	$369.86	$389.07
Disabled/Elderly	$1,300.39	$1,367.48	$1,438.00
Medicare	$13.82	$14.55	$15.33

Projected Cost Savings for CY 2016 – CY 2018

An adjustment was made to reflect expected savings from the management of care. The estimated savings were based on the expected degree of healthcare management (DOHM). DOHM is a concept used by Milliman to quantify the expected utilization and average charges of a population based on the extent to which its care is being managed. A 0% DOHM would indicate a relatively unmanaged plan while a 100% DOHM would indicate a very well managed plan. A high DOHM would result from the efficient and effective use of multiple cost management programs (pre-admissions testing, large case management, concurrent review, etc.), but would also be influenced by such factors as geographic distribution of the population. The application of the DOHM concept reflects the interrelationships between services as management is being implemented. For example, the use of additional lower cost services such as office visits in place of higher cost services such as Inpatient.

Table 6 shows the net savings after shared savings and is equal to Table 2 minus Table 5.

Table 6 PMPM Savings After Shared Savings			
	CY 2016	**CY 2017**	**CY 2018**
Medicaid Adult	$31.30	$30.58	$29.73
Wellness Plan	$28.48	$27.82	$27.05
Medicaid Child	$14.88	$14.54	$14.14
Dual Eligibles	$25.07	$24.49	$23.82
Disabled/Elderly	$85.54	$83.58	$81.26
Medicare	$1.20	$1.18	$1.14

Table 7 shows the total savings before the removal of the state's share and is equal to Table 1 times Table 6

Table 7 Total Cost Savings			
	CY 2016	**CY 2017**	**CY 2018**
Medicaid Adult	$2,460,024	$2,884,122	$3,364,746
Wellness Plan	$13,360,765	$15,661,369	$18,273,474
Medicaid Child	$3,212,056	$3,766,395	$4,395,336
Dual Eligibles	$1,776,987	$2,083,051	$2,674,403
Disabled/Elderly	$5,415,880	$6,350,141	$8,149,515
Medicare	$1,208	$1,426	$1,818

Table 8 shows the FMAPs by eligibility category.

Table 8 FMAPs By Eligibility Category			
	CY 2016	**CY 2017**	**CY 2018**
Medicaid Adult	55.54%	55.54%	55.54%
Wellness Plan	100.00%	97.50%	94.50%
Medicaid Child	68.88%	68.88%	68.88%
Dual Eligibles	55.54%	55.54%	55.54%
Disabled/Elderly	55.54%	55.54%	55.54%
Medicare	55.54%	55.54%	55.54%

Federal Share of Cost Savings

Most of the projected savings accrue to the Federal Government. The following table provides the total savings and the estimated ROI from the program assuming a $42 million investment.

Table 9 shows the federal share of the savings and is equal to Table 7 times Table 8.

Table 9 Federal Cost Savings and ROI Assuming $42 Million Investment			
	CY 2016	**CY 2017**	**CY 2018**
Medicaid Adult	$1,366,297	$1,601,841	$1,868,780
Wellness Plan	$13,360,765	$15,269,835	$17,268,433
Medicaid Child	$2,212,464	$2,594,293	$3,027,508
Dual Eligibles	$986,938	$1,156,926	$1,485,363
Disabled/Elderly	$3,007,980	$3,526,868	$4,526,240
Medicare	$671	$792	$1,010
Total	$20,935,115	$24,150,555	$28,177,334
ROI	50%	58%	67%

The anticipated cost savings reflect expected savings from the management of care. The savings was estimated using an assumed degree of healthcare management (DOHM). DOHM is a concept used by Milliman to quantify the expected utilization and average charges of a population based on the extent to which its care is being managed. A 0% DOHM would indicate a relatively unmanaged plan while a 100% DOHM would indicate a very well managed plan. A high DOHM would result from the efficient and effective use of multiple cost management programs (pre-admissions testing, large case management, concurrent review, etc.), but would also be influenced by such factors as geographic distribution of the population. The application of the DOHM concept reflects the interrelationships between services as management is being implemented. For example, the use of additional lower cost services such as office visits in place of higher cost services such as Inpatient.

The following table illustrates the changes in medical costs and utilization assumed under the proposed ACO structure. These changes are shown by category of service (e.g, Inpatient, Outpatient, etc.). As the management of healthcare increases, utilization is expected to decrease. In some cases, the average cost per service increases, which is due to elimination of less severe services.

The factors were developed using Milliman's proprietary Medicaid TANF/AFDC Health Cost Guidelines.

Table 10 Impact of Assumed Level of Healthcare Management			
Category of Service	Utilization	Average Charge	PMPM
Inpatient	83%	101%	83%
Outpatient	81%	106%	86%
Medical (Physician & Other)	89%	98%	87%
Rx	100%	100%	100%
Capitated Services	98%	98%	98%

The proposed ACO structure includes a sharing of savings with providers. The overall savings of the program have been reduced for the estimated amount of shared savings.

Table 11 Estimated Percentage of Shared Savings	
Yr 1 CY 2016	25%
Yr 2 CY 2017	30%
Yr 3 CY 2018	35%

Actuarial Certification

In performing the financial analysis, we have followed generally accepted actuarial principles and practices. In my opinion, the results of financial analysis were developed in accordance with generally accepted actuarial principles and practices, and are appropriate for the populations to be covered and the services to be furnished under the contract. The actuary certifying these financial results meets the qualification standards of the American Academy of Actuaries and follows the standards of practice established by the Actuarial Standards Board. We have relied on historical data and background information provided to us by the State, its fiscal agent, and other publicly available information. We have reviewed the data for reasonableness but have not audited the data. I am a member of the American Academy of Actuaries, and I meet the qualification standards for performing this analysis.

Timothy F. Harris, FSA, MAAA

December 18, 2014